

Selected essays on
Racism and Mental Illness
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Black Politics and Schizophrenia

Jonathan Metzl

Jonathan Metzl is a professor at Vanderbilt University. A Guggenheim fellow, he has written for medical, psychiatric, and popular publications, including *MSNBC*, *The Lancet*, and *NPR*. His books include *The Protest Psychosis: How Schizophrenia Became a Black Disease* (2010), and *Prozac on the Couch: Prescribing Gender in the Era of Wonder Drugs* (2003), and he co-edited *Against Health: How Health Became the New Morality* (2010).

Black Power activists in Detroit were swept up into the mental health system after protesting. They ended up in psychiatric hospitals and diagnosed with schizophrenia. Political protest in the '60s became coded as mental illness.

WILL HALL Your book describes how the evolution of schizophrenia diagnosis intertwines with the politics of the 1960s. How did you get

interested in this?

JONATHAN METZL In my first book *Prozac on the Couch*, I looked at how years of ads for depression and anxiety medications represented drugs as white middle class “mothers’ little helpers.” It was amazing to me the invisibility of people of color in those representations.

WH And the psychiatric portrayal of black Americans has always been culturally bound. Where does that begin?

JM In the 1860s the American surgeon Samuel Cartwright coined the diagnoses “drapetomania” and “dysaesthesia aethiopsis” for black slaves who ran away from their masters. Cartwright said that because blacks are physiologically better off in slavery, then they must be insane if they’re running away. He advocated whipping and other kinds of “treatments” for this disease.

This was clearly racist, but it was picked up by psychiatric authors over the course of the next 30 or 40 years. So there is a clear history of diagnosing black bodies as insane for reasons that have largely to do with political or social factors.

WH Wanting freedom was considered a mental illness?

JM Yes, and at the time this was given credence in medical literature.

WH And how does racism persist up through the modern era?

JM We’ve supposedly learned the lessons of the past, like the Tuskegee experiments from 1932 and 1972, where blacks were denied syphilis treatment and allowed to die in the name of research. But there are many less obvious present-day examples. Today African-American men are anywhere from four to five, six, even seven times more likely to be diagnosed with schizophrenia

In one of the medical charts I looked at, a woman was diagnosed just for creating a public disturbance and embarrassing her husband.

compared to other groups.

WH Instead of being diagnosed with anxiety, depression, or something less severe.

JM Yes, and what's interesting is that this isn't just coming from white doctors. Clinicians of color are just as likely to over-diagnose black men with schizophrenia. These are structural attitudes about race.

WH And prior to the protest era of civil rights and Black Power, how was schizophrenia defined?

JM Psychiatry in 1952 described schizophrenia as a relatively mild personality condition that led to splitting of the personality. You would see it in popular culture: women's magazines talked about the schizophrenia of being a housewife. There was a famous 1948 Olivia de Havilland movie called *The Snake Pit*, where three days into her marriage a white woman ends up developing schizophrenia, manifested in her inability to recognize her husband. Different kinds of magazines, newspapers and films all assumed schizophrenia was an illness of white female docility, and also sometimes white male genius.

WH And one of the main symptoms for schizophrenia in women was losing interest in being a wife or a mother?

JM Yes. In one of the medical charts I looked at, a woman was diagnosed schizophrenic just for creating a public disturbance and embarrassing her husband.

WH So psychiatry is labeling women who aren't conforming to gender expectations and then locking them up in hospitals. This is social control to keep the gender status quo in line.

Cartwright said that because blacks are physiologically better off in slavery, they must be insane if they're running away. He advocated whipping and other kinds of treatments for this disease.

JM Certainly. At the time people thought they were performing state of the art science, but when we look back historically it becomes very apparent what was happening: in the mother's little helper era, 70-75% of Valium prescriptions were written to middle-class women.

WH So originally it was housewives who were being diagnosed schizophrenic, and schizophrenia wasn't inherently feared or associated with violence and aggression, but then a change took place?

JM The main story of my book is about Black Power activists in Detroit who were swept up into the mental health system after protesting. They ended up in psychiatric hospitals and diagnosed with schizophrenia. Political protest in the '60s became coded as mental illness. Criminality and hostility became increasing described in the *DSM*, where they were absent before.

The second version of the *DSM* came out in 1968, an important year of protest. The new *DSM* added aggression, hostility and projection to the criteria for schizophrenia, used male case studies instead of female, and now said things like, "patient is hostile, he blames other people for his problems." Angry black men are depicted as suffering from new forms of schizophrenia, manifest by aggression and violence. The diagnostic code language changed, and lo and behold, you see increasing numbers of African-American men diagnosed with schizophrenia.

WH You give an example of a medication advertisement that reflects this.

JM I came across an ad for Haldol, a major tranquilizer used for schizophrenia, in the *Archives of General Psychiatry*. The ad appeared right after the aftermath of riots, and shows an angry, protesting black man in the street, shaking his fist at the viewer. The text says "Assaultive and belligerent? Cooperation begins with Haldol."

WH So psychiatry diagnoses black protesters as mentally ill. In the same era political dissidents in the USSR are also being diagnosed as mentally ill, and treated with the very same drug: Haldol. The memoirs of Soviet dissidents describe the drug as torture.

Your book focuses on a hospital near Detroit, which was a cen-

ter of the Black Power movement and the Nation of Islam, as well as labor unrest and the auto workers movement. There were also big riots there. One story you tell is of Abdul Rasheed Kareem.

JM Kareem came from a military family, started out life in the housing projects of Detroit, and got into some trouble as a youth. He went to Vietnam, and while visiting his family on leave he was in a fight with some white strangers as he was walking to his house. He was swept up by a police raid, and severely abused while in prison.

He had a prison conversion to the Nation of Islam, and became an active protester, angry and hostile. He starts to develop mental symptoms: he starts to hallucinate and becomes delusional. They ship him to Ionia State Hospital for the Criminally Insane.

WH He has a lot of really good reasons to be angry.

The diagnostic code language changed, and lo and behold, you see increasing numbers of African-American men diagnosed with schizophrenia.

JM Absolutely. And it was an ethical dilemma for his doctors. He fits the criteria for what their profession tells them is the illness, so what do they do? Do they say, no this is a social construction,

and refuse to help him? Do they see if they can treat him? Is the problem the doctor? Is the problem the system? Is problem the diagnostic manual? Is the problem the patient?

WH So there actually were doctors who said, "Wait a second here, maybe he's got good reasons to be angry, maybe he's not just crazy?" There was some kind of debate?

JM I've done oral histories with a lot people in the hospital and there was a tremendous amount of debate about whether they were doing the right thing or not. They faced a dilemma. What were their options at the time? They couldn't really let him go, because they were already under

court order. The system trumps the individual very often in cases like this. I don't think that's an excuse, but change means seeing the institutional and structural context in addition to the problems of individuals.

WH That is eerily reminiscent of the situation today, where so many people working in the mental health system are questioning it and calling it broken, but also say they are constrained by the larger structures and can't do anything differently.

So what finally happened to Kareem?

JM The court ordered him to remain in the hospital until restored to sanity. His relatives tried again and again to get him released, and in my book I reproduce a series of heartbreaking letters from family members to doctors. He finally ends up, like many of these people, "lost to follow-up." I assume he was transferred out to another facility, and very often people died in the hospital. So not a happy ending at all.

We've supposedly learned the lessons of the past, like the Tuskegee experiments from 1932 and 1972, where blacks were denied syphilis treatment and allowed to die in the name of research. But there are many less obvious present-day examples.

WH Or hopefully he managed to get away for psychiatry and just didn't have any more contact. And is his story just one example of what happened to many black men, not just in Ionia Hospital, but in many hospitals around the country?

JM In my research, we looked at about 800 randomly selected charts. As increasing numbers of African-American men were brought to Ionia in the '50s, '60s and '70s, the hospital became a black facility. It went from being roughly 15% African-American in the 40s to being about 70% in the '70s. And the community became increasingly concerned about the

possibility that people might run away, and what they might they do in the community. In 1977 the hospital literally becomes a prison: the mental health system was taken over by the corrections system and became what's called the Riverside Correction facility, a medium security prison. So here really is Foucault's worst nightmare: one system taking over the other, and the goal is social control. Hospitals become prisons literally overnight.

Although this was the era of supposed deinstitutionalization, a lot of the black men that I talked to were not deinstitutionalized, they were not let go on the streets. Instead they were either recast as prisoners or were farmed out to other prisons and ended up coming back to Riverside Correction facility a couple of months later.

WH Your book describes how Malcolm X, the black nationalist leader, was seen as paranoid schizophrenic and insane for his views.

JM As schizophrenia became an illness that was increasingly associated with angry black male protest, you see national examples of FBI profilers, leading psychiatrists, and others diagnosing black protest leaders as schizophrenic.

That's just one part of the story; the rhetoric of schizophrenia and the associations with violence also played out in Black Power discourse itself. People like Malcolm X, H. Rap Brown, Stokely Carmichael, and even Martin Luther King Jr. were talking about race and schizophrenic

This isn't just coming from white doctors. Clinicians of color are just as likely to over-diagnose black men with schizophrenia. These are structural attitudes about race.

violence. There was a real debate: is this an illness of dopamine and the mind, or something caused by society and civilization? Is this the result of racism? Some were saying we don't have to fix dopamine in black people's minds, we need to change the system. If we don't do that, violence is going to be the result. So there was a real debate about who was causing illness and what the implications were.

WH There is a real mental derangement that takes place, connected with anger and rage, but is it truly an illness or a response to oppression?

JM In the late '60s the whole society was grappling with the question "What does it mean to be normal, what does it mean to be crazy?" The country was erupting into violent conflict and there were social problems being protested and a war in Vietnam. There was a huge social discussion about madness, sanity and what the nature of the current crisis was, both for the individual and society.

WH You pointed out that black men are much more often diagnosed as schizophrenic than whites, which of course means more use of force, more discrimination, and less hope for recovery. We also know that people of color are put in restraints, locked in hospitals against their will, and overmedicated at a higher rate than are whites. At the same time there is a greater neglect of services and support: blacks are underserved by the system. How should we engage this complex disparity?

JM The medical system is actually pretty aware of these racial disparities. People within the black activist psychiatry community argue that overdiagnosis of schizophrenia is because black men are being driven crazy by racism, so of course they're going to have schizophrenia more than white men. On the other hand, in the realm of biological science psychiatrists argue that culture shouldn't matter, and schizophrenia should occur in all people equally because of deep biological structures that cause it, so the problem is in the bias in the diagnosis.

The way that all this is usually dealt with is so-called cultural competency training: train doctors to be more culturally aware and sensitive to the racial or ethnic backgrounds of patients, so that they'll be less likely to put them in the wrong category.

Today African-American men are anywhere from four to five, six, even seven times more likely to be diagnosed with schizophrenia compared to others.

So here really is Foucault's worst nightmare: one system taking over the other and the goal is social control. Hospitals become prisons literally overnight.

more engaged in the larger political issues about mental health disparities and pharmaceutical company influence in more progressive ways.

It's really important to look at the '60s as a case study: fitting something in the category of mental illness automatically meant that we didn't have to pay attention to the meaning of it as political protest. The minute you feature a black protester in a Haldol ad, then who cares what he's saying. He's insane. ■

But while on the one hand this is a good thing, it also doesn't impact the issues I'm talking about here, about race and diagnosis. The diagnostic code itself has a racialized history, and the treatment system is embedded in a racialized system. So even though we should continue training doctors to be culturally competent, we should also teach them to be *structurally* competent. Psychiatry needs to become

Afro-Caribbean Black Mental Health

Philip Morgan

Philip Morgan worked for over 15 years in human community development, including as project coordinator for Tower Hamlets African and Caribbean Mental Health Organization (THACMHO) in London. He established *The Spiritual Health and Well Being Experience* on Galaxy Radio and is today a consultant and teacher.

Part of healing is to reclaim and understand history.

WILL HALL What was your experience with the mental health system?

PHILIP MORGAN Well, I've got a strange kind of history...

I come from a broken family, I didn't grow up with a mother or father, and as a child I was very sick and had several chronic illnesses, asthma and eczema which was very bad from head to toe. I was often described as being leprous.

As a result of those things and not having any parents, I became extra marginalized. I also couldn't attend normal school due to having a hearing problem and various other learning difficulties. So I was in special schools up until the age of 8 or 9 and in the care of social services and the state throughout my childhood.

Growing up as a child I always questioned things, and I realized that the normality that existed in society was not really normal at all.

In 1993 I was evicted and was homeless for

5 years. Prior to that I had a breakdown, felt unable to cope, didn't go out or communicate, and got evicted.

I didn't want to go back into the system due to memories from my childhood of being institutionalized. So I avoided seeking any form of psychiatric help. I went through a period of a year where I barely spoke to anyone. I had some crazy times. Eventually I did see some psychiatrists who worked with homeless agencies. They were sympathetic to the concerns of vulnerable people and suggested that counseling might be helpful. So I went for counseling for a couple of years. They referred me to a housing agency where I was able to get accommodation and rehoused. That helped me calm down, refocus and come out of my shell a bit. Because of that shell, I had been very subdued.

WH Given your fear of institutionalization, was it difficult to get help?

PM In my experience, when you go to any kind of government or medical institution, the first thing they want to do is give you drugs. Most of the time they're unsympathetic to your needs and concerns. I had seen people who have gone through the system and when they emerge they're completely different people. So I avoided the system as much as I could.

WH So it was helpful for you to not be medicated?

PM Yes. I had a doctor prescribe me some pills that I took a few times. But the moment I took the pill, my brain said "there is something wrong here." It's like my spirit was questioning my actions. I decided that if I felt depressed, I had to face it straight on, rather than suppress the feelings and perhaps create more of a monster later down the line. So I stopped taking the pills.

WH Beyond being in institutional care and being marginalized your whole life, what else pushed you into that breakdown?

PM There were a lot of things. I had financial and girlfriend issues. I was living in the inner city, and there were a lot of junkies. Even though I'm a large man, I felt scared to leave my house. I lost a lot of material possessions. I couldn't deal with anything because I was trying to work, but the work available for me at the time was very low pay. I started study-

ing social sciences and was good at it, but what I was thinking as a social scientist was too radical for the institution. I failed my exams. That also led to depression.

I went through a period of a year where I barely spoke to anyone.

WH Tell us about your work with Tower Hamlets African and Caribbean Mental Health Organization, which began in 1996 out of concerns that a disproportionate number of African and Caribbean people were being detained at Saint Clements Psychiatric Hospital in London.

PM THACMHO is run by the members, all of whom have had some kind of negative mental health experience with mental health services and or life in general. We do events like last night's panel in Brixton "Satisfy Your Soul: The Disintegration of Self Through the Illusion of Materialism." We were able to get Caribbean meals into the hospital, pushed for more medication information, and promote the social rather than the medical model. Part of healing is to reclaim and understand one's history.

Our first project examined the lives of five Africans who lived near the Tower Hamlet bowers during the late 1700s and wrote about their experiences. We created a tour based on their work. We then wrote a book about them called *Power Writers* because we believed that they had power. Their power came from their writing. The subtitle of the book is, *And Their Struggle Against Slavery*. The slave trade was abolished in 1807. We think that the power writers were the real abolitionists because their written work encouraged others to work towards ending the slave trade.

WH This occurred at a time when people believed Africans and Caribbeans were incapable of having human feelings, thoughts or ideas.

PM Precisely. Blacks were not allowed to read, write, or allowed access to any form of knowledge. Society wanted to keep these people underground. Through work of the power writers, people realized they could read and write, and at a time when many white people were unable to do so. It was really an outstanding achievement.

WH How does publicizing these experiences help black mental health

today?

PM It helps people realize that African History is not just about slavery. It's also about personal achievements by those facing extreme daily adversity. Today's black people can identify with this. I feel different about myself knowing my history isn't all about slavery; my people have achieved monumental things. It makes me feel better about the history of African and Caribbean people, and makes me more prepared and able to look forward to the future.

WH Can you talk about the holistic approach to your work?

PM Oppression doesn't just occur in psychiatry. It's widespread in terms of the food we eat. We encourage our members to come off medication but also eat healthy and avoid recreational drugs. I know many who took no drugs until going into hospital and being medicated. When they came out of the hospital they now had a drug mindset. It is then easy for people who have been in psychiatric care to become hooked on recreational drugs.

WH How does generational trauma play a role in mental health?

PM "Post-traumatic slave syndrome" is serious; the experiences of the past become intergenerational. For example, it was very common for slave masters to beat their slaves. Many slaves inherited that particular action and beat their children. This got passed on. I remember being beaten as

I had seen people who have gone through the system and when they emerge they're completely different people. So I avoided the system as much as I could.

a child, and know people who still beat their children. It's not just about the physical beatings but the effects that follow: being scared to resist, scared of change, or scared of challenging authority for fear of suffering the consequences. We need to think about how we live out our histories and then address these issues.

WH What project is THACM-

HO currently working on?

PM Our latest project documents African history at the Tower of London. African people lived and worked at the tower as slaves, servants and

Post-traumatic slave syndrome is serious: the experiences of the past become inter-generational.

soldiers. In addition, some of the crown jewels, gold, and arms in the tower also came from Africa. These are divided into museums all over Britain. We talk about Africa's contribution as a whole. What the Greeks learned and imparted was brought from Egypt and Ethiopia. The teachings of Plato, Aristotle, and Archimedes are the foundations of our knowledge, and they

came originally from Africa. ■

Depression & Oppression

Alisha Ali

Alisha Ali is an associate professor at New York University and co-editor (with Dana Crowley Jack) of *Silencing the Self Across Cultures: Depression and Gender in the Social World* (2012).

Most research is geared toward medication, the brain, and individual pathology. Social context and economics are ignored. Our study runs counter to that, and suggests depression implicates society as a whole.

WILL HALL Blaming serotonin imbalance for depression (the “monoamine hypothesis”) has been discredited; tell us about your study that looks at the role of poverty in depression.

ALISHA ALI The feelings associated with depression, extreme sadness, low sense of self-worth, lack of motivation, are connected to poverty, and poor people are more often diagnosed with mental illnesses, including depression. But real-life experiences of people living in poverty are not represented in the research literature. There is a belief that poverty doesn't matter, because depression is a "brain problem."

WH And so research participants tend to be privileged white college students, or patients at well-funded clinics.

AA In our study we looked at people in poverty who met the criteria for depression (we used the standard *DSM* criteria as it was necessary to speak to the existing literature). They were enrolled in a micro-credit loan program that trained them for small collective business ventures. Members share accountability for loan payback and receive better interest rates. These programs have not been used much in the US, but have been very successful in so-called developing countries and have a repayment rate well over 90%.

WH People who were both poor and depressed got collective micro-loans for businesses. What was the impact on their depression?

AA Micro-credit loans are very effective, and participants were successful in becoming economically self-sufficient. When we looked at their depression levels before the loans and then after, there was a significant decrease in their depression.

WH Did they receive any other kind of treatment or mental health care that might have affected the outcome?

AA No. Less depression was specifically linked to the financial empowerment from being in the successful micro-loan program.

WH So the approach is anti-poverty instead of antidepressants. And this was a National Institute of Mental Health funded study, the gold standard in research. Are there any other studies like this?

AA The research worlds of psychiatry and community economic develop-

ment are rarely combined: we looked for other studies, but our research is unique. Most other research is geared toward using medication to treat depression, which means focusing on the brain and individual pathology. Social context and economics are ignored. Our study runs counter to that assumption, and suggests depression implicates society as a whole.

Our political and social systems are based on silencing marginalized individuals so they don't have the wherewithal to create positive change. The mental health establishment itself becomes part of that system.

WH In mental healthcare thinking we lose the common-sense understanding that poverty is depressing.

AA When people have something we call “depression,” (or, if you don’t want to use that term, feelings of anguish and persistent unhappiness in their lives), there are many options that might be more effective than medication and which the person might feel good about doing. Changing lives from an economic point of view is very different than taking a pill. The first is empowering. The latter,

to many, is disempowering. When people become more self-sufficient, it builds resources that provide scaffolding for themselves, their children and future generations. Compare this to a reliance of medication. Not only are there side effects, but you have a daily reminder, in the form of a pill, to think of yourself as a defective individual with a problem inside of you.

WH This highlights the cultural assumptions that go into our understandings of depression.

AA Depression carries stigma, meaning you are somehow personally ineffective in moving forward in your life. I interviewed a woman who had suffered with extreme sadness and lack of motivation for years. She was given a diagnosis of depression and internalized this label. When I asked her about aspects of her life where she could make a change, she

said, “I’m a depressive. I’m not a person who can do that.” She had internalized this label as central to her identity as a person.

Our political and social systems are based on silencing marginalized individuals so they don’t have the wherewithal to create positive change. The mental health establishment itself becomes part of that system, in effect controlling and keeping people where they are. So this is connected to oppression and social inequality.

WH What about guilt? When people receive a label that says, “it is not your fault, it’s a chemical imbalance in your brain,” it can be incredibly relieving. The message is that you lack personal ability to ever control things, and so you are not to blame.

AA Most of my interviewees saw their depression as yet another defect. Not only were they socially incompetent, unable to maintain relationships or a job, but now their brain is also defective. When medications do work, it’s like taking a pain pill when you have been hit on the head by a falling brick. The pill might make you feel better, but the cause of the pain was external.

In these beliefs there is a collusion between drug companies, psychiatrists and patients as well, who deeply want to be liberated from their self-blame.

WH It redirects away from social change, and it reminds me of Michel Foucault’s view, that social control can be internalized by a kind of inner surveillance, trained by helping institutions.

Your work also looks at racial inequality. We know mental health services are underutilized by people of color, which is a civil rights issue of equal access to care. So “reducing stigma” and increasing access is emphasized in ethnic minority communities.

Changing lives from an economic point of view is very different than taking a pill. The first is empowering. The latter, to many, is disempowering.

AA The drug industry needs profit to succeed, and this requires targeting as many people as possible. Anti-stigma programs to increase access to services are very popular with pharmaceutical companies. They encourage people to seek medical help in the current system, which grows the market for pills. And they also normalize medication by promoting the idea depression is an individual defect.

WH Jonathan Metzl says professionals need “structural competence” about the social forces that drive mental suffering.

AA This is not to say many psychotherapists aren’t well intentioned in wanting to be “culturally competent.” But the real need for change rests not only in the individual but in culture as a whole. Instead, people learn to talk about their problems in ways that are in effect marketing the drugs to everyone they meet.

WH Anti-stigma campaigns become sophisticated tools to overcome obstacles to market reach. The story is, “I was suffering but finally overcame the stigma to get services. I was saved by treatment with medication.” People become sort of walking pill advertisements. I want people to get help too, but the advertising and pharma-funded support groups twist that into marketing.

AA Being on medications is today so widespread in part because the medication is less stigmatized and more open and accepted.

WH We again see how understanding mental health reform defies simple equations and sound bites. You’ve also worked with immigrant women of color, tell us about that.

AA They face the same challenges other patients experience, but in far more extreme ways. For patients already marginalized because you are not white, English isn’t your first language, and you’re not familiar with the system, there is more power differential between you and the person providing services to you. Add the cultural gap and patients are at great risk.

One woman I interviewed had been assaulted in Colombia before immigrating. Her male psychiatrist tried to be “culturally sensitive” by telling her Colombia is “very much a rape culture.” At first she felt relieved

of blame, but months later, after he made several other derogatory comments about her country, she realized he was really pretending to know the culture. When her anger came out towards him, she was even more severely stigmatized: social workers, nurses, and the psychiatrist saw her as a “problem patient” resistant to diagnosis.

WH Doctors are trained to treat sickness, not communicate with people. Is cultural derogation a common theme?

AA Yes, usually by white male psychiatrists pretending to understand a person’s culture. For example, an African woman learned the aunt who raised her from birth had died, but she wasn’t able to go home for the funeral. Her husband brought her to the emergency room because she was crying uncontrollably, and she was admitted to an inpatient facility. The next morning she told the nurses she felt better and thought she could go home. She explained that during the night she heard her elders whispering in her ear that her aunt was fine, and because of this she had made peace with not being present at the funeral. But the staff wrote in her chart that “an aggressive treatment plan is recommended for these auditory hallucinations.” She is not the quiet, calm patient who has experienced a recent death in the family that they might see from their own cultural background. She is very dramatic, talks with her arms, moves her hands, raises her voice and wasn’t just crying she was screaming. She was expressing in a way that made sense to her as normal. But to the medical staff it was abnormal, and they used it as a reason to confine her.

WH What is a normal experience in one culture can be seen as a hallucination and a symptom of a broken brain in need of medication in another. Pathologizing anger is also common.

AA Women especially are expected not to show anger, it’s seen as “inappropriate.” This becomes a means of controlling people and

Women are expected not to show anger, it’s seen as “inappropriate.” This becomes a means of controlling people and keeping them in their place.

keeping them in their place so that they are not able to engage in forms of resistance. Foucault wrote about psychiatry equating mental illness with moral degeneracy, and using confinement and treatment to protect soci-

When we looked at their depression levels before the loans and then after, there was a significant decrease in their depression.

ety. This containment for the sake of social safety means people who are incarcerated in prison and people in psychiatric institutions have astoundingly similar life conditions that brought them into these institutions.

It's more readily explained by understanding oppression, discrimination, and poverty than it is by looking at a scan of a person's brain.

Oppression, when we unpack that word, means a higher risk of violence, a greater risk of poor nutrition, higher chronic stress, all of which affect the body and the brain. We now know that the brain is physically shaped by experience, and repeated trauma changes the way that the brain looks on a brain scan. And yet the whole idea of mainstream psychiatry is that someone's brain is defective by nature, that there are predispositions and genetic inheritance and given differences between a normal person's brain and abnormal person's brain from the beginning. But why can't someone start normal and then become abnormal through the impact of oppression? We know this is possible, because we know that social influences can change a person's biology. The brain and even our genes are physically shaped by experience.

WH Science has viewed the poor and criminals as innately biologically abnormal since the days of phrenology and eugenics. Now the word "predisposition" and "risk factors" carry the same message. What are some other examples of race dynamics?

AA For many immigrant women, their psychiatrist is the one person they see outside their own family, and comes to represent the culture of their new country. They start to have what psychologist Dana Jack calls externalized self-perception, which is seeing oneself not through your own

eyes, but through the eyes of others.

And there can be a massive split between how the women talk about their experience and the way psychiatrists view them as patients. For example, a Caribbean woman was labeled as “depressed” following the loss of her husband. She described how although her psychiatrist was compassionate and tried to understand her culture, he couldn’t. In her chart the psychiatrist wrote, “upon admission the patient reported having no current sexual partners, despite being dressed in a sexually provocative manner, as is often the way with women from the Islands.” That was one of the first sentences in his notes that went into her medical record.

WH It is especially disturbing that such a view was written openly in the guise of professional assessment.

AA Researchers actually did a careful study on the *Diagnostic and Statistical Manual Casebook*, a textbook that gives fictitious case examples in order to illustrate different mental disorders, and is used worldwide to train psychiatrists, nurses, social workers and therapists how to properly diagnose people. When they looked at these case examples, they found

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that women of color were significantly more likely to be described in sexualized terms like “sexually provocative.”

WH If that’s in the official school training manual, it’s probably just the tip of the iceberg of what is happening in clinics.

AA The psychotherapeutic setting is not some kind of value-free, decontextualized scientific space. It is a microcosm of society’s bias. Stereotypes are perpetuated with every new generation in psychiatry who refer to the Casebook and are teaching the Casebook. Changing this requires more than simply training psychotherapists to be more culturally competent. It requires more than ending stigma so that peo-

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ple of so-called other cultures can embrace the idea that they, too, might be mentally ill and need medication. It requires stepping away from the foundations of psychiatry, and looking to non-medical alternatives that deal with real issues. It means no longer pathologizing individuals as an excuse to avoid addressing social ills.

WH The entire mental health framework needs to be rethought in as community development, to think not in terms of mental illness, but in terms of empowerment and connection.

AA We need to move away from diagnostic labeling and the public education campaigns around it. With diabetes and cardiovascular disease there is a strong link between raising medical awareness and improving people's lives. That is not what happens with depression and mental illness; the medical model doesn't work for these experiences. The labels themselves can be damaging. An approach that relies on medical labeling and the expertise of someone outside the community takes away from the strengths within the community. We need to look at *existing* strengths communities have to change the conditions of their lives.

But why can't someone start normal and become abnormal through the impact of oppression? We know this is possible, because we know social influences can change a person's biology. The brain and even our genes are physically shaped by experience.

WH Such as micro lending programs that help people gain financial independence.

AA The people I interviewed have a history of unemployment and going through the prison system, and they are afraid their sons might go into the prison system. Expanding programs like micro-lending requires an investment, but the savings in the long run come from keeping people out

**It means
no longer
pathologizing
individuals
as an excuse
to avoid
addressing
social ills.**

of the cycle of poverty and incarceration. From a simple economic point of view, preventive approaches save money and make more sense. This is what psychiatry and psychology are really supposed to be about: enhancing conditions so people feel fulfilled and productive in what matters to them. That creates a positive legacy for the next generation. ■

Prison Madness

Terry Kupers

Terry A. Kupers, MD, MSP, is a professor at The Wright Institute. He provides court expert testimony on the psychological effects of prison conditions. He is author of *Prison Madness: The Mental Health Crisis Behind Bars and What We Must Do About It* (1999) and received the Exemplary Psychiatrist Award from the National Alliance on Mental Illness.

Today there are more people with mental illness inside prisons than confined anywhere else; state hospitals are small by comparison.

WILL HALL The US has changed dramatically since the survivor movement began: hospitals are no longer the main institutions of medical confinement. Tell us about the prison crisis.

TERRY KUPERS The US incarcerates people at a much higher rate than any other country, there are about 2.5 million people behind bars (according to the Prison Policy Initiative), and many more under prison control through probation and parole. This far surpasses our closest competitors: the Soviet Union before it broke up and South Africa before the end of Apartheid.

WH The United States has less than 5 percent of the world's population, but almost a quarter of

all the world's prisoners. That's even more prisoners than China today, which we consider a much less free country. In fact, there are more black men under prison control today than ever were slaves in the US.

What is driving prison growth?

TK The War on Drugs is central. Starting in the 1970s, individuals using illegal drugs were incarcerated, which is foolhardy as a treatment intervention because we know that if you go to prison with a substance abuse problem, when you come out you will still have a substance abuse problem. Add on longer punishments, "three strikes" laws and mandatory minimum sentences, and the prison population keeps increasing. Crowding leads directly to violence, suicide, and psychiatric issues.

WH And there's been no decline in drug use as a result of the War on Drugs, which President Nixon launched as a form of political repression just as the Black Power movement was reaching its height. Tell us about how prisons are also a race issue.

TK When you walk into a prison, it's shocking; you see the racism of our country. 50% of prisoners are African-American. Another 20%-25% are Latino and Native American. If you go to the solitary confinement units, the punitive segregation, they're mostly people of color. Desirable programs that provide training and vocational skills have disproportionately white prisoners.

WH You've written that today's prisons are a throwback to the snake pit mental asylums of the 1940s with their rampant abuse, horrible conditions, injustice, and torture. What do prisons do to people's mental health?

TK Resources going into our mental health system declined steadily since the 1970s, while prisons expanded. Today there are more people with mental illness inside prisons than confined anywhere else: state hospitals are small by comparison. There is a disproportionate number of people with emotional problems among the homeless, who tend to get locked up. We know from studies that prison crowding increases violence, mental breakdown, and suicide. So the imprisonment binge has exacerbated

and created serious mental illness.

There was an historic wrong turn with the “tough on crime” approach to crime begun in the ‘70s, which dismantled rehabilitation and education programs. Robert Martinson wrote a famous research study claiming that rehabilitation didn’t work, which was seized on by conservatives and became one of the most famous papers in criminology. When 4

years later Martinson himself wrote that his own study was flawed and he had gotten it wrong, that actually rehabilitation does work, his recantation was ignored. So the punishment approach grew and prisons expanded, which added to crowding, and combined with idleness because there are no programs. In California, basketball courts were filled with bunk beds three high, so you’d get 150-200 men in what used to be a gymnasium. They can’t be supervised, there’s just too many people. The result is a lot of violence, a lot of rape. By the 1980s, prisons were out of control. There were a lot of what were called ‘riots’ that were often actually protests by prisoners demanding more humane conditions. The Prison Rape Elimination Act was passed in 2003, and mandates a “zero tolerance” attitude towards rape. Even so, rape is very prevalent and sexual abuse occurs quite a lot.

WH Prison authorities and the media dismissed political protests as just dangerous rioting, presumably without demands or meaning?

TK Correct. Authorities could have addressed the real problem in the ‘80s, but instead of reducing crowding and supporting rehabilitation programs, they resorted to solitary confinement, often in supermax security segregation units where prisoners are alone nearly 24 hours a day. The 80s began these supermax prisons and now over 40 states and the federal government have built them. There is no programming, no rehabilitation, almost no educational opportunities. Think about being locked in

There was a wrong turn with the “tough on crime” approach to crime begun in the ‘70s, which dismantled rehabilitation and education programs.

a space the size of your bathroom for years with no human contact. This causes or exacerbates mental illness.

WH Tell us more about the impact of isolation.

TK Anyone will break down and go through anguish and despair. It's an "attribution error" to blame the person's innate proclivities for the breakdown rather than blame the extreme conditions they are put in. This is shown again and again in the research. The Stanford Mock Prison Experiment done in the early 1970s by Philip Zimbardo and Craig Haney divided ordinary student volunteers into roles as prisoners and guards. After two days they had to stop the experiment because of the sadism and cruelty that broke out. And that was with Stanford University professors watching! In prison, nobody is watching and the abuse goes on for years.

WH I do believe we need to hold people responsible, but we can do it by also addressing the social context, as with restorative justice. We tend to say the violence comes from the prisoner, that "you are the problem, you are a psychopath, you are bad." Or we blame bad guards. But it's really the conditions themselves.

Authorities could have addressed the real problem in the '80s, but instead they resorted to solitary confinement.

TK When I started going into Pelican Bay state prison in California and supermax prisons, I was told these prisoners are the worst of the worst. But when I started interviewing them, I discovered that wasn't the case. Some of them were average people who had run into trouble. A stunning proportion were suffering from serious mental illness. These individuals tend to have trouble following directions and falling in line. In prison, they are then punished with solitary confinement.

In his book *Asylums*, Erving Goffman described a person being brought to a hospital against his will. When the person would argue and be uncooperative or protest, the authorities would say "See, he really is abnormal and disturbed." On the ward no one listens to him, his clothes

are taken away and he has no way to express himself. So he gets angry and hits someone, and they say “See, we were right to admit him.” They put him in isolation and he acts more bizarrely, for example writing with feces on the wall. Goffman saw that when you take away their self-expression, people become more and more extreme in their efforts at expression. This is happening in the supermax prisons today, where people are screaming, cutting themselves, writing on the walls with feces. And people don’t hear about it because it so difficult to visit prisoners.

Crime is the new face of racism. Seventy-five percent of people in prison for a felony did not commit a violent crime, yet our society uses fear of violence to justify extremely harsh sentences.

WH Is it true that supermax prisons contain a disproportionate number of prisoners who were protesting conditions?

TK Guards can write a ticket for anybody for anything. Prisoners who sue the prison system for denying them their rights often end up in a supermax. Such punishment tends to be retaliation. There are also disproportionate numbers of political prisoners in

supermax prisons, prisoners who have a very high level of consciousness about what’s going on, including religious leaders and Muslims.

WH How are things made worse by sleep issues?

TK Sleeping in these situations is extremely problematic, particularly when someone is up all night screaming, for instance someone with mania. Then the other prisoners can’t sleep either. Deprivation of sleep makes every condition worse.

WH Isolation also means loss of social contacts key to mental health.

TK Prisoners need quality contact with loved ones throughout their prison term if they are going to do well when released. This requires good visiting and educational programs. But prisons are far from urban cen-

ters where prisoners, particularly the prisoners of color, come from. It's almost impossible for their families to see them, and the state doesn't help at all. Family members are harassed, searched in extremely abusive ways, and barred from visits. Rather than promote social contact to help prisoners succeed when they are released, the opposite is done.

WH What does research show about rehabilitation and offering more support to people who commit crimes?

TK Research shows rehabilitation works. But politicians and people who make money building prisons and supplying food or guns to prisons have a self interest in keeping prison populations large. They are the ones who claim that rehabilitation programs don't work.

WH This is all connected to deep prejudice and fear in society.

TK Crime is the new face of racism. Seventy-five percent of people entering prison for a felony did not commit a violent crime, yet our society uses fear of violence to justify extremely harsh sentences. If you brutalize people in prison, they will fail when they get out: they won't have the skills necessary for anything other than prison. This is especially true for people with mental illness.

WH One of the most shocking situations that affects mental health is sexual abuse.

TK Sexual abuse in prison is endemic. Among men, it tends to be prisoner on prisoner because staff do not provide a safe place, so one group of prisoners can victimize another. Among women, the abusers tend to be the staff themselves. It is hard for women to come forward because the retaliation is massive.

WH What do you mean by retaliation?

TK If a woman complains that an officer is sexually abusing her, she can be ticketed for a minor offence. Even if it's bogus, it will then keep the woman from visiting her children, and it might get her sent to segregation. Worse, she may be sexually abused again as retaliation for reporting the initial sexual abuse.

WH And prisoners often have their own histories of abuse to begin with.

TK A huge portion of prisoners had been massively traumatized as children prior to incarceration. When they experience more sexual abuse, for example forced strip searches, the repeated trauma makes them suffer more. In the men's prisons, there are gangs or groups of people who look out for each other. A perpetrator doesn't want to rape someone with tough friends, so they pick on the loners. And people with mental illness are more prone to be loners.

WH What prison reform strategy would work?

People with substance abuse problems don't belong in prison. We should be offering them treatment programs or a good job that might motivate them not to do substances.

TK We have to work at all levels. Our public schools are failing, which sends people into drugs, crime, becoming homeless and getting arrested. We're not providing adequate access to public mental health care, so people fall through the cracks and get arrested. We also need to stop sending so many people to prison in the first place. Historically, the juvenile system also provided education, counseling, and rehabilitation; today this is no longer the case. Children are being put on trial as adults in ever-increasing numbers. Finally, people with substance abuse problems don't belong in prison. We should be offering them treatment programs or a good job that might motivate them not to do substances. People with more money have lawyers, so they stay out of jail, while low-income people and people of color are less likely to have adequate legal representation. Dra-

conian sentencing reflects this income split. Individuals caught with crack, which is more used by low income inner city people, receive a sentence ten times than if they were caught with powdered cocaine, which is used more by middle class white people.

WH Actually, a greater percentage of whites than people of color in the US use illegal drugs; for example, a 2011 Substance Abuse and Mental

Health Services Administration study showed the rate of cocaine use is twice as high among whites as blacks. And a greater percentage of whites are drug dealers than blacks. But in a low-income community, it tends to be on the street so it's more visible, unlike in the suburbs or in downtown offices.

If you brutalize people in prison, they will fail when they get out: they won't have the skills necessary for anything other than prison.

TK We must stop crowding prisons and stop sending substance abusers to prison. We need to put rehabilitation policies back together. Where people do need to be in prison, we have to ensure they receive humane treatment

and that we address what got them into so much trouble to begin with. A positive development occurred in Mississippi, where I was an expert witness in a successful lawsuit against the state for its prison conditions. This led to Mississippi reducing the number of prisoners in its supermax prison, and as a result, violence across the entire Mississippi Department of Corrections dropped. That disproved the rationale for their supermax strategy.

WH So there are precedents for a very different approach to crime, such as the restorative justice movement.

TK Yes. In England, Grendon prison provides therapeutic communities where prisoners meet to make decisions for themselves rather than being told what to do every minute of every day. Participants at Grendon have a much lower violence rate while incarcerated and when they get out have a much higher rate of succeeding. And there are places where restorative justice approaches are being tried, including mediated dialogues between perpetrators and victims. Restorative justice consistently results in a much better sense of resolution and greater community reintegration than the punishment based, "law and order" approach. ■

Indian Country

David Walker

David Walker, PhD (Missouri Cherokee) is a psychologist, writer, and musician who has consulted since 2000 with the 14 Confederated Tribes and Bands of the Yakama Nation. He is the author of *Tessa's Dance* (2012) and *Signal Peak* (2014), and has written for *Ethical Human Psychology & Psychiatry* and the *Journal of Clinical Psychology*.

Today labels of “horse-stealing mania” and “feeblemindedness” have been replaced by “bipolar” and “ADHD.”

“Historical trauma” among American Indians and Alaska Natives is a metaphor for the intergenerational effects of genocide, cultural destruction, and forced assimilation. These same oppressive forces echo through Indian Country today: the biomedically-dominated US Indian Health Service (IHS) mental health system descends directly from the American eugenics movement.

From 1899 until 1933, the Hiawatha Asylum for Insane Indians in Canton, SD imprisoned “insane” Indians, often until they died. “Indian lunacy” determinations captured native people who were displaced or resistant to federal policies. In the 1920s, US psychologists began using highly biased tests to prove the inferiority of children forced from their homes and removed to federal- and mission-run boarding schools. Today labels of “horse-stealing mania”

and “feble-mindedness” have been replaced by “bipolar” and “ADHD.” IHS use of diagnostic labels and first-response psychiatric medicating (chemical restraint) are just contemporary versions of coercion, indoctrination, and thought reform.

To influence change, for years I’ve tried to provoke a reexamination of this history and its contemporary manifestations. My few scholarly publications seemed doomed to dusty university shelves. So I dramatized the difficult journey of a Yakama Indian girl and her curmudgeon mixed-blood IHS psychologist in two indie novels: *Tessa’s Dance*, and its sequel, *Signal Peak*. I’m honored they’ve been

well received by the Yakama Nation community and have won several awards. And I wish I could answer my spiritual brother, Dr. Eduardo Duran (recognized internationally for his work on historical trauma), who asked me about my novels, “What in any of this is fiction?” ■

**“Indian lunacy”
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nation has done so much against blacks; now has to do things in their favor. Blacks need compensation: a promissory note is in default.

We need to see each other instead as a multiplicity of identities: race, gender, class ... that give us different privileges and oppressions. We don't solve the race problem by acting neutral. Blindness to privilege's consequences is a recipe for maintaining injustice. ■

We need to see each other instead as a multiplicity of identities: race, gender, class, that give us different privileges and oppressions.

Death by Cop

Jenny Westberg

Jenny Westberg's writing has appeared in *The Oregonian*, *Portland Mercury*, and other media. She is the Portland mental health examiner on Examiner.com, a board member of the Mental Health Association of Portland, a Portland Hearing Voices facilitator, and co-creator of the Women Survivors of Sexual Trauma support group.

In the U.S. each year police kill an estimated 1,200 or more persons.

James Chasse died after a brutal police beating in 2006. He was not committing a crime. He was not even suspected of a crime.

Portland cops chased him down, tackled him, shot him repeatedly with a Taser, beat him, and kicked him, ignoring his pleas of "Mercy! Mercy!" When an ambulance came, officers sent it away. A photograph taken by a horrified bystander shows Chasse hogtied, face-down and broken, encircled by police officers chatting and drinking coffee.

Finally, in the back of a patrol car, struggling for breath, bleeding from his mouth, and with his head covered with a blood-soaked "spit sock," Jim went into convulsions and died. He was 42 years old.

James Chasse was an artist, a musician, and a poet. But all that mattered to police was that he was a "schizophrenic."

Chasse's family sued. And city attorneys countered with a nauseating blame-the-victim strategy: they wanted to tell the jury that "Chasse's preexisting physical and mental condition, his resistance to the officers' lawful orders and his inappropri-

ate conduct is [sic] what caused his death.” The City lost that legal battle, and eventually settled for \$1.6 million.

But the killings continued. In 2010, 25-year-old Aaron Campbell, a black man in emotional crisis after learning of his brother’s death, was fatally shot by police as he tried to surrender. He was unarmed. The killing so shook the city that *The Skanner*, a leading Portland black publication, advised residents in crisis *not* to call 911.

Two months later Jack Dale Collins, 58, was ordered by police out of a park restroom where he was cutting himself. Seemingly dazed, he did not respond to commands quickly enough, and so the officer shot him dead. Just two weeks before, Collins had walked into the Central Precinct police station and asked for mental health help.

And again that same year, Keaton Otis, a 25-year-old African-American, was at a traffic stop when police shot him so many times that another cop, arriving on scene, said it “sounded like World War III.” Otis’ mother said they too had been trying to get him help for mental health issues.

More deaths from police violence: Craig Boehler, age 46. Darryel Dwayne Ferguson, age 45. Marcus Lagozzino, age 34. And others...

As the bodies fell, the US Department of Justice (DOJ) opened a civil rights investigation, and the following year they issued their findings: the Portland Police Bureau was indeed violating the civil rights of a protected class. There was a “pattern or practice” of using excessive force against persons with psychiatric disabilities.

But in response the City of Portland failed to present a satisfactory plan for amending police conduct. So in 2012 the DOJ sued the city. After months back and forth, the parties reached a settlement agreement, including a large number of police reforms. But then, only seven weeks later, the city announced its intention to go back to court and appeal the court’s ruling.

Even with reforms, the casual prejudice and routine maltreatment of persons with differences or diagnoses goes on, and not just in Portland,

Police shot him so many times that another cop, arriving on scene, said it “sounded like World War III.”

***The Skanner*, a leading Portland African-American publication, advised residents in crisis *not* to call 911.**

crisis. Blacks and people of color are especially at risk.

Remember your mad brothers and sisters. Memorialize them. Print their names, print the names of the officers who killed them. The grim practice of “Protect and Serve” predation flourishes in silence and shadow. Shine the light on the moral chasm that allows killing with impunity. Our lives have value. ■

everywhere.

In the US police kill an estimated 1,200 or more persons each year.

In every city, every day, police are targeting the most vulnerable: the disabled, the poor, the homeless, the voice-hearers, the ones in